



DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS  
ELEANOR SLATER HOSPITAL  
P.O. Box 8269  
Cranston, RI 02920  
401.462.3433 – OFFICE  
401.462.6958 – FAX

### APPLICATION FOR ADMISSION

( ) CRANSTON UNIT

( ) ZAMBARANO UNIT

*\*\*OPTIMAL LOCATION WILL BE DETERMINED BY PATIENT'S NEEDS. PREFERENCES MAY BE HONORED, BUT CANNOT BE GUARANTEED*

Name of Applicant: \_\_\_\_\_

Residence: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Current Legal Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Name of Insured if other than Applicant: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Federal ☐ Medicare Replacement Plan (HMO) ☐ Agency: \_\_\_\_\_

If Supplemental Plan to Medicare Please Specify: \_\_\_\_\_ ID #: \_\_\_\_\_

Blue Cross #: \_\_\_\_\_ Veteran's #: \_\_\_\_\_ Other : \_\_\_\_\_  
ID #: \_\_\_\_\_

Medical Assistance #: \_\_\_\_\_  
(R.I. Only) If pending, list name of office/worker to contact

### **Include Photocopies of All Medical Coverage Cards**

#### ***Referral From (Home, Nursing Home, Community Agency, etc.)***

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

#### ***Family, Significant Other Supports***

<u>NAME</u>	<u>ADDRESS</u>	<u>TELEPHONE (HOME/WORK)</u>	<u>RELATIONSHIP</u>
-------------	----------------	------------------------------	---------------------

*How often have family, significant other supports visited the applicant in the last two months?*

- ( ) Daily ( ) 2-3 times per month  
( ) More than a week ( ) Once a month  
( ) Once a week ( ) Less than once a month  
( ) N/A

*How often have they provided care/assistance to the applicant in the last two months?*

- ( ) Daily ( ) 2-3times per month  
( ) More than a week ( ) Once a month  
( ) Once a week ( ) Less than once a month  
( ) N/A

#### **Advance Directive:**

Living Will ( ) Yes ( ) No ( ) Unknown

Durable Power of Attorney for Healthcare: ( ) Yes ( ) No ( ) Unknown

Is Guardianship Pending? ( ) Yes ( ) No ( ) Unknown

Applicant's Signature (If Unable to sign, Guardian or Relative)

Date

***Eleanor Slater Hospital is a facility that provides Long-Term Acute Care; Patients accepted for admission MUST QUALIFY FOR HOSPITAL LEVEL OF CARE. If / when patients no longer qualify for hospital level services as determined by the treatment team, discharge to a less restrictive environment becomes mandatory under Federal guidelines.***

Reason for Referral to Eleanor Slater Hospital (Circle All That Apply and Elaborate Below):

Medical

Behavioral

Psychosocial

Psychiatric

---

---

---

---

---

Has the Patient Sought Admission Elsewhere? (Circle One):                      YES                      NO

**If YES,** Where? What were the decisions? \_\_\_\_\_

---

---

---

---

**If NO,** Please Explain. \_\_\_\_\_

---

---

---

---

Does the Patient Have a Discharge Goal After Eleanor Slater Hospital? (Circle One)                      YES                      NO

**If YES,** What is the Goal: (Please check options)

- |  |  |
|--|--|
| <input type="checkbox"/> Home(Alone)     | <input type="checkbox"/> Assisted Living               |
| <input type="checkbox"/> Home (w/Family) | <input type="checkbox"/> Group Home                    |
| <input type="checkbox"/> Nursing Home    | <input type="checkbox"/> Other (Please Specify): _____ |

Who Will be Responsible for This Patient's Care: (Name / Address\*\*)

***\*\*This individual's active, early involvement in the admission process is strongly encouraged to facilitate the eventual discharge goal. A conference may be requested prior to admission.***

---

---

---

---

**If No Discharge Goal Exists, Please Explain Long-term Goals for This Patient (1-5 Yrs From Now):**

---

---

---

---

---

---

**ALL INFORMATION MUST BE COMPLETE AND ACCURATE. PLEASE INCLUDE COPIES OF SUPPORTIVE DOCUMENTATION** (Physician's progress notes, Physician's orders, Nurses' notes, consultations, Therapist's notes, etc.)

*To be completed by physician, nurse, or case manager* – Please check appropriate boxes

**ACCESS/OSTOMY**

- ☐ NG/G/J Tube
- ☐ IV/IV Access
- ☐ Trach
- ☐ Ostomy

**MEMORY**

- ☐ Normal
- ☐ Mildly Impaired
- ☐ Moderately Impaired
- ☐ Severely Impaired

**COMMUNICATION**

- ☐ Normal
- ☐ Language Barrier
- ☐ Comprehends
- ☐ Can Relate Needs
- ☐ Aphasic/Non-communicative

**BEHAVIOR**

- ☐ No Significant Disorder
- ☐ Appears Depressed
- ☐ Wanders
- ☐ Noisy
- ☐ Withdrawn
- ☐ Physically Assaultive
- ☐ Verbally Abusive
- ☐ Intrusive
- ☐ Combative During Care
- ☐ Sexually Inappropriate

**SENSORY**

- ☐ Hearing Impairment
- ☐ Vision Impairment

**CONDITIONS**

- ☐ Pressure Sores/Wound Care
- ☐ Contractures

**CONTINENCE**

- ☐ Continent
- ☐ Incontinent Urine/Feces

**Please attach a description of any particular management issues (Patient and/or Family) of which the Eleanor Slater Hospital Admission Team should be aware of.**

<b><u>ADL</u></b>	<b>Independent</b>	<b>Needs Assistance</b>	<b>Unable</b>	<b><u>ALLERGIES:</u></b>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ambulating w/ device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathe Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>DIET:</u></b>
Dress Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feed Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toilet/Commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bedpan/Urinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SPECIAL EQUIPMENT**

Special Equipment Needed: \_\_\_\_\_

Air Fluidized Beds: \_\_\_\_\_

Other (describe): \_\_\_\_\_

**FOOD & FLUID INTAKE:**

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

**HEIGHT:** \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_

DIAGNOSES/PROBLEMS

I. \_\_\_\_\_

IV. \_\_\_\_\_

II. \_\_\_\_\_

V. \_\_\_\_\_

III. \_\_\_\_\_

MEDICATIONS (Dose & Route) TPN & IV

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PROGNOSIS

( ) GOOD

( ) FAIR

( ) POOR

( ) GUARDED

\_\_\_\_\_

\_\_\_\_\_

TREATMENTS: (Check Box)

☐ PT (Describe) \_\_\_\_\_

Respiratory: \_\_\_\_\_

☐ OT (Describe) \_\_\_\_\_

Skin/Wound Care: \_\_\_\_\_

☐ Speech (Describe) \_\_\_\_\_

Other: \_\_\_\_\_

INFECTION CONTROL

☐ MRSA

☐ VRE

☐ Special Isolation (Describe) \_\_\_\_\_

**Name of Physician:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Date of Last Examination:** \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_